

MUNN (W.P.)

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of
inflammatory phimosis

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THE OPERATIVE TREATMENT OF INFLAMMATORY PHIMOSIS AND THE USE OF THE SHARP CURET AND STRONG BICHLORID SOLUTION FOR CHANCROIDS.¹

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THE treatment of chancroid located in the coronal sulcus and covered by a long prepuce has as a rule always been unsatisfactory. When the inflammatory reaction creates a practically irreducible phimosis, there has been felt the necessity for operative interference, mingled with the dread of further chancroidal infection of the whole of the fresh wound-surface. In so late a publication as Morrow's *System of Genito-urinary Diseases and Syphilology*, Dr. Edward Martin states that in five cases of circumcision for inflammatory phimosis due to sub-preputial chancroid, in every case a complete circular chancroidal infection occurred. My own experience was until recently practically in accord with his and that of other writers on the subject. Within a short time an opportunity has occurred in

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eight cases to put in practice a method the results of which have been eminently satisfactory both to myself and to the patients.

The procedure is as follows: (1) anesthetize the patient, preferably with chloroform; (2) thoroughly irrigate the sub-preputial space with a strong mercuric-chlorid solution, not weaker than 1:1000, and scrub the parts thoroughly with bichlorid gauze pledgets; (3) perform circumcision rapidly, immediately grasping the raw surface left by the retraction of the skin, with one hand protected by bichlorid or iodoform-gauze; (4) slit the mucous membrane of the prepuce dorsally, back to the corona, and immediately scrub it thoroughly with a pledget of bichlorid gauze, which is at once thrown away; (5) with a sharp curet thoroughly scrape the chancroidal ulcer, removing all granulations clean down to healthy tissue; (6) wash away the *débris* with a bichlorid solution, and then mop up the curetted surface, either with Monsell's solution, full strength, or with a 1:100 solution of bichlorid; (7) trim the mucous membrane and suture it to the skin with silkworm-gut sutures placed rather close together; (8) rub aristol or iodoform into the line of coaptation and then into the curetted surface; (9) dress with a thick strip of iodoform-gauze held in place by a rubber band.

In every case the results attained by this method have been practically perfect. The circumcision-wound has united throughout by first intention, with the exception, in two instances, of a trifling point of infection, which healed kindly when touched with pure carbolic acid. The original chan-

croid in every case was converted at once into a healthy, rapidly granulating ulcer, almost entirely free from discharge. The first dressing, as a rule, has been allowed to remain in position three days, although in two instances it remained a week, and when removed healing was practically complete.

In one case only was the dressing changed after twenty-four hours, mainly in order to inspect the glans penis, the integrity of which I feared might be destroyed, as the chancroid had eaten deeply into the body of the penis back of the corona. Inspection showed the deep ulcer filling up with healthy granulations with astonishing rapidity, and in a week the patient was practically well.

This method seems of importance because :

1. It indicates the uniform and satisfactory results to be obtained by the proper application of antiseptic measures in the treatment of a condition that has always been regarded as refractory and disappointing, as well as disgusting.

2. It indicates curettage as the ideal treatment of chancroid.

To the latter conclusion there is the objection that few patients suffering from what they consider a trivial disorder will submit to anesthesia in order to permit of curettage. The objection is weighty as a practical consideration, but does not invalidate the correctness of the method as a surgical procedure. The uniform rapidity of recovery stamps it as superior to other usual methods of treatment for those patients who are willing to submit to it.

I am impelled to notice the attitude of so eminent an authority as Jacobson, who, in his recent work

on *Diseases of the Male Organs of Generation*, seems to have little fear of infection of the wound, but does not appear to accomplish primary union nor even to expect it in hospital-cases that have no infective complications. His treatment of the chancroidal sore with nitric acid is certainly radical and antiseptic; but while it destroys the specific infection, it causes sloughs and necessitates the use of warm fomentations and charcoal poultices, to which he advises resort, while at the same time it absolutely interdicts all hope of primary union. The thorough use of the curet followed by momentary application of strong bichlorid solution is open to none of these objections.



